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Hearing on
Medicare Provider Service Networks

Testimony Presented
By

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The American Academy of Actuaries is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification standards and standards of actuarial practice, a major purpose of the Academy is to act as the public information organization for the profession. The Academy is nonpartisan and assists the public policy process through the presentation of clear, objective analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials and congressional staff, comments on proposed federal regulations, and works closely with state officials on issues related to insurance.

The American Academy of Actuaries appreciates the opportunity to provide comments to the House Commerce Committee Health and Environment Subcommittee on the important issue of appropriate regulation of health insurance entities that assume risk. The Academy hopes that you find these comments helpful as you consider the issue of having provider-sponsored organizations participate in the Medicare program, such as in H.R. 475 and the Administration's 1998 budget proposal.

The actuarial profession is uniquely qualified to examine the various financial risks associated with providing health insurance and health care benefits. Actuaries are experts in evaluating all types of health insurance risk bearing entities' financial status, based on the nature of the insurance risks and the increasing volatility of the U.S. economy. Among other things, actuaries estimate future contingent liabilities. Based on those estimates, they determine whether a health insurance risk bearing entity has adequate surplus and reserves to meet future obligations with sufficient margin.

The Subcommittee on Health and Environment has asked the Academy to discuss solvency regulation; why it is important, the various risks involved with providing health care benefits, and the consequences of inadequate or inappropriate solvency regulation.

The Need for Solvency Regulation

Solvency laws and regulations are primarily in place to protect the public from the consequences of an insolvency. Therefore, the Academy's work has generally assumed that the risk to the public should drive solvency regulation, not the risk to other entities involved with the insurer. In particular, this assumption implies that solvency regulation should not be a function of who owns or controls the risk bearing entity, unless this impacts the financial risk to the public.

At the request of the National Association of Insurance Commissioners (NAIC), these principles were followed when the American Academy of Actuaries Health Organizations Risk-Based Capital Task Force developed recommendations for a health organizations risk-based capital formula. In particular, the NAIC asked the Academy to develop a formula which could apply across all types of licensed health risk takers.

Risk-based capital (RBC) formulas establish benchmark levels of necessary surplus and capital. Under RBC, a minimum surplus level is calculated for each health plan, based on its unique characteristics. The characteristics reflect the health plan’s insurance products, assets, provider relationships, reinsurance programs and others. As actual surplus falls below various multiples of this minimum, different regulatory actions are triggered. These standards exist today for life insurance companies and casualty insurance companies through formulas developed by the NAIC, with help of the Academy. There is also a minimum surplus requirement for HMOs which is not risk-based. In addition, the Blue Cross & Blue Shield Association has developed similar standards for their members, and many Commissioners of Insurance have developed formulas for

their specific states.

These currently adopted NAIC RBC formulas produce different minimum capital levels for a given block of insurance. This lack of consistency creates different capital standards for organizations providing health coverage, depending on their corporate structure or often even the branch of state government under which they are regulated.

Therefore, one of the primary goals of the Academy for the RBC formula was to establish a consistent RBC measure applicable to the wide variety of organizations that are likely to provide health coverage in the future. The Academy's recommendation to the NAIC included a unified standard for all types of health organizations, intended to be applied to all risk takers.

The NAIC is considering adoption of these standards. Congress should encourage uniform, adequate, and consistent solvency standards for all health insurance risk bearing entities, in order to protect the public. These entities include insurance companies, HMOs, health service corporations (like Blue Cross/Blue Shield plans), physician-hospital organizations, self-insured employers, trusts of various types, and health care providers themselves.

Current Solvency Structure

The goal of a solvency structure under health care reform is to provide a regulatory and industry framework to measure, monitor, and ensure that health insurance risk bearing entities have the financial capacity to provide health care for insureds. There are widely differing solvency structures in place today, depending on the nature of the health plan. For example, a self-insured employer-sponsored health plan is exempt from state insurance regulation by federal law. Such a plan is subject to the financial constraints of federal law only, which are more concerned with avoiding overfunding than underfunding.

Most of the solvency standards applicable to health insurance risk bearing entities today are part of the current state regulatory framework. These standards include: risk-based capital requirements, reserves to absorb fluctuation in asset values and reporting, financial statements based on statutory reporting requirements, licensing requirements, asset investment limitations, the Insurance Regulatory Information System, company examinations by state regulators, minimum contingent reserve and liability standards, premium regulation, capital management polices, and outside rating agencies. Few of these solvency mechanisms currently apply to PSOs. There is also a system of state guarantee associations that serve to protect policyholders when a failure of a covered organization occurs. PSOs are not currently covered under these associations.

As shown by the above list, the current regulatory structure is complex. Each element of the framework is intended to protect against specific perceived risks, and is inter-dependent with

other elements of the framework. For example, uniform financial reporting standards are needed to get consistent capital measures, before RBC standards can be applied. Therefore, it is risky to exempt entities from portions of that structure without a full understanding of what the implications are.

It is also important to understand the impact of having different solvency regulation or capital standards for different risk-bearing entities. Different standards will create artificial competitive advantages for certain risk-takers.

The Academy's recommended HORBC formula does reflect a theoretical difference in risk when an individual provider provides services directly. The formula reflects our belief that if an individual provider is taking on the risk, the provider could absorb a certain level of fluctuations in costs, thereby lowering the risk of financial fluctuation. We reiterate, however, that this element of the formula is not a function of who owns the risk-taking organization.

What are the Risks?

Health insurance risk bearing entites either guarantee reimbursement for health benefits or, as in the case of PSOs and some HMOs, guarantee to provide care directly. There are a variety of financial risks connected with these guarantees. These include insurance risks, risks inherent in managed care arrangements, business risks, antiselection risks, regulatory and legal risks, and

various investment risks. While each risk does not necessarily occur everywhere, they all exist somewhere. The Academy's monograph number 4, entitled "Actuarial Solvency Issues of Health Plans in the United States" has a detailed discussion on the various risks, who takes them, and tools for managing the risks.

How Managed Care Entities and PSOs Take the Risk

There are many kinds of risk takers in the health care delivery insurance marketplace. This includes providers of benefits, and those who contract with those providers. The providers of benefits include insurance companies, HMOs, health service corporations (like Blue Cross/Blue Shield plans), physician-hospital organizations, self-insured employers, trusts of various types, and health care providers themselves.

Those entities who contract with benefit providers are also at risk. These include the insureds themselves, reinsurers (who are insurers to insurance companies), and health care providers. As the NAIC white paper on risk-bearing entities states, "the ability to provide services does not meaningfully reduce the actuarial risk present in the health care context". This statement is key to understanding the need for appropriate uniform solvency standards for PSOs.

Risk-bearing entities, such as PSOs, assume insurance risk when they market an insurance plan or promise benefits to members. There is a promise to pay for delivering a service which the

participant relies on in the same way as insurance. The consequences of non-payment are real to the participant and just as catastrophic as they would be under a similar insurance plan. Since the risk is similar, it seems reasonable that PSOs should be subject to regulation that are the same as an insuring entity making a promise to deliver services and provide benefits.

The Academy's HORBC Task Force allowed for credits where risk is transferred, provided the entity assuming the risk is subject to the same formula.

Considerations on Solvency Regulation Structure

Solvency is best monitored and regulated in the entity that is guaranteeing coverage. In the current environment, this would be at the health insurer level, which is the entitity providing the insurance contracts.

Some forms of managed care have had a significant impact on the degree of predictability of costs while others have not. Some examples of managed care which reduce risk include approaches which fix prices (such as negotiated fee schedules), provider risk sharing (such as withholds or bonuses and capitations), and restructure of the cost basis itself (salaries, negotiated budgets). These are recognized in the Academy's recommended HORBC formula.

Conclusion

Under the Administration's 1998 budget plan, PSOs would be allowed to participate in Medicare under minimum federal standards, with states allowed to impose more stringent standards after four years. If Congress is concerned about a level playing field for those participating in Medicare, it will be necessary to ensure that PSOs are subject to similar regulatory and solvency requirements as HMOs and traditional insurers. The Academy is concerned that the proposed minimum solvency standards for PSOs might create undue risk to the public.

We believe there is great need for solvency standards and regulation which depend on risk levels, rather than other factors. These standards should be used to determine whether a health plan can begin operation and continue operation.

The greatest risk to health plan solvency will occur during the initial years of implementation. With this in mind, in order to minimize this risk, the full spectrum of the regulatory structure should be reviewed in light of each element's role in protecting the public. Appropriate solvency safeguards with adequate oversight and enforcement could greatly reduce the potential for increased insolvency risk.